HIGHLAND FAMILY PRACTICE

4460 S. HIGHLAND DR. # 400
SALT LAKE CITY UT, 84124
(801) 272-4111

DATE _________________

PATIENT NAME____ PREFERRED NAME_________________________
FIRST M.I. LAST

PATIENT ADDRESS ____
STREET ADDRESS (PLEASE NO P.O. BOXES)

____
CITY STATE ZIP CODE

HOME PHONE # (______)______________________ DATE OF BIRTH _____/_____/________ GENDER (circle one) M F

WORK PHONE # (_____)______________________ MARITAL STATUS (circle one) S M W D RACE_____________

CELL PHONE # (______)_______________________ TEXT MESSAGING OK? ______ ETHNICITY__________________

EMPLOYER ____

WORK ADDRESS ____
STREET ADDRESS

____
CITY STATE ZIP CODE

PERSON RESPONSIBLE FOR PAYMENT ____
FIRST M.I. LAST

MAILING ADDRESS____
STREET ADDRESS (NO PO BOXES)

____
CITY STATE ZIP CODE

HOME PHONE # (______)______________________ WORK PHONE # (______)_____________________

RELATIONSHIP TO PATIENT __________________ DATE OF BIRTH _______/_______/___________

INSURANCE #1 _____________________________ GROUP # ______________ I.D._______________________

ADDRESS___________________________________ NAME OF INSURED _________________________________

____ RELATIONSHIP TO PATIENT_________ D.O.B. __________
CITY STATE ZIP CODE

EMPLOYER _______________________________________

INSURANCE # 2 ______________________________ GROUP # _______________ I.D.______________________

ADDRESS____________________________________ NAME OF INSURED _________________________________

____ RELATIONSHIP TO PATIENT _________ D.O.B.__________
CITY STATE ZIP CODE

EMPLOYER ____

EMERGENCY CONTACT # 1____________________ PLEASE LIST ALL MEDICATION ALLERGIES:

PHONE # (______)_______________________________ ____

EMERGENCY CONTACT # 2____________________ AUTHORIZATION FOR ELECTRONIC CONFIRMATIONS?

YES NO

PHONE # (______)_____________________________ PHARMACY____

DO YOU HAVE A LIVING WILL OR ADVANCED DIRECTIVE? PHARMACY PHONE #(______)___________________

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<OVER>